

Cardiology & GIM training – example training programme

The aim is to produce Cardiology specialists who are excellent all-round clinicians and capable of running a medical unselected take if required by future employers. By the end of training, cardiology trainees must meet all the criteria required for CCT in Internal Medicine reflecting the emphasis on generalism that the GMC has supported since the Shape of Training report.

The principles underlying this are:

1. Training will be capability rather than time based
2. Capabilities may be realised as appropriate during any attachment
3. The organisation of training programmes for Internal Medicine Stage Two is the responsibility of the deaneries or local offices of NHSE WT&E.
4. Flexibility and pragmatism will prevail.
5. Rotations must be sustainable to avoid burnout.

Guidelines

1. Educational Supervision
 - a. Trainees should have a ‘lead’ ES who is a Cardiologist (ES-C)
 - b. When training in IMS2, all trainees will have appropriate CS and ES in IM (ES-IM). If the ES-C has GIM experience in training, from the IMS2 curriculum or in clinical practice, they can also act as ES-IM. They must exercise particular care in obtaining and considering detailed feedback from CS who are knowledgeable about trainees’ full performance in IM and they should include this in the ESR.
 - c. To inform the ARCP process, an ESR that reviews all the IM capabilities is required in each year of training and an ARCP outcome form that covers both cardiology and IM must be completed at each ARCP.
2. Acute Unselected Take (AUT)
 - a. Involvement in AUT is required for an indicative minimum three years
 - b. AUT does not need to be entirely of hours but should be a fair combination of in and out-of-hours duty.
 - c. AUT does not have to be a full day.
 - d. 750 unselected urgent and emergency patients (minimum) should be seen during IMS2.
 - e. There should be some ‘keeping in touch’ AUT outside the defined IM blocks during years when trainees are on full Cardiology training. This can comprise
 - i. 1 AUT session per month (1 in 30)
 - ii. 2 weeks immersive AUT in an AIM unit
 - f. AUT GIM experience during DGH Cardiology blocks should be on a full or split rota (i.e. Single or shared slot on the medical rota)

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3. IM Ward work

- a. IM continuing care / ward work experience can be obtained through management of medical co-morbidities affecting patients in Cardiology wards.
- b. The requirement is for 12 months minimum IM exposure over the full training programme. An indicative 3-months of this should be within the final training year but this can also be delivered as a 1-month immersive block in an AIM unit.
- c. Trainees may continue one session per week in Cardiology (e.g. OP clinic / Echocardiography session etc) during this period.

4. IM clinics

- a. Trainees should attend an indicative 20 clinics out with Cardiology over the training programme.
- b. It is suggested that these could be in specialties with clinical relevance to Cardiology such as Diabetes, Respiratory Medicine or Geriatric Medicine

5. Example of training programme

Year	Aug - Jan	Feb - Jul
ST4	12 months Cardiology <i>2 weeks immersive AIM block</i> or <i>1 in 30 AUT</i>	
ST5	6 months DGH Cardiology <i>Including AUT GIM rota</i>	6 months Cardiology
ST6	12 months Cardiology <i>2 weeks immersive AIM block</i> or <i>1 in 30 AUT</i>	
ST7	6 months DGH Cardiology <i>Including AUT GIM rota</i>	6 months Cardiology
ST8	11 months Cardiology+ <i>1 month block of immersive AIM</i> (PREFERRED OPTION) or 9 months Cardiology + <i>3 months AUT GIM rota</i>	

- The two 6-month DGH blocks could be delivered over a single year in ST4, 5, 6 or 7. This may aid programme design and reduce the need for movement between LEPs
- Trainees on an immersive GIM block should **not** be included on a Cardiology specialty rota

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